

superior orbital fissure can be damaged by displaced fractures of the bony boundaries of the fissure or haemorrhage. Since our patient had no associated fractures or haematoma demonstrated on the CT scan, it was felt that the transmitted force from the trauma gave rise to a neuropraxia of the nerves, which then resolved resulting in the rapid recovery of the patient's ocular movements. Neuropraxia is defined as the mildest type of focal nerve injury producing clinical deficits and is followed by complete recovery.<sup>4</sup> The presence of Bells phenomenon in our patient, despite loss of upgaze, suggests that Bells phenomenon is a very strong stimulus for upward ocular movement, much stronger than either voluntary or oculocephalic movements.<sup>5</sup>

In reviewing the limited literature on the treatment of the condition, it appears that the prognosis is usually good especially in those with undisplaced fractures of the fissure. Those cases that are, however, associated with comminuted fractures disrupting nerve function have a poorer outlook. Surgery can be considered when there is evidence of optic nerve compromise either by bony fragments impinging on the nerve or in cases associated with a nonresolving orbital haematoma if after 3–4 months there is evidence of optic atrophy.<sup>1</sup> In the absence of optic nerve dysfunction, the patient could lose vision if surgery resulted in iatrogenic damage to the nerve.<sup>3</sup> It is difficult to know whether the use of steroids in superior orbital fissure syndrome helps, as there are not a sufficient number of cases to give a definitive answer. Theoretically steroids may decrease the inflammatory reaction around the nerves, giving rise to a speedier recovery. Whether or not it affects the final outcome, it is not possible to say.

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Sir,  
**Cataract surgery for natural rubber latex allergic patients**

We would like to thank Mr Beare for highlighting the regional variation in the management of natural rubber latex (NRL) allergic patients. This variation is partly due to the lack of evidence-based recommendations for management of NRL allergy. It is hoped that our review article<sup>1</sup> would help ophthalmic units to examine the literature surrounding NRL allergy such that they can formulate their own protocols for operating on latex-allergic patients. As reiterated by Mr Beare, the prevalence of patients with true severe NRL allergy, where contact with NRL allergen causes a life-threatening reaction, for example, bronchospasm and anaphylaxis, is probably extremely low and may never be known due to difficulties in clinical diagnosis, *in vivo* and *in vitro* testing. *In vivo* testing of patients for NRL allergy is considered the definitive confirmatory test, but ethical and safety considerations exist.<sup>2,3</sup> Definitive diagnosis of NRL hypersensitivity revolves around the consideration of the clinical history with confirmatory *in vitro/in vivo* testing.<sup>4</sup>

The management of NRL allergic patients, as with all kinds of risk management, involves the balance of the potential risks of operating on that patient in the normal operating environment *vs* the potential disruption caused by changing to an NRL-free environment. Again, variation exists between different hospital trusts in how the relative risks are perceived. Local policies also appear to be influenced by the subspecialties involved in their creation. In many hospital trusts, it is the anaesthetic department's responsibility to produce guidelines for NRL-free environments.

This is understandable, since it is often the anaesthetist's responsibility to cope with the life-threatening complications that can arise.<sup>5-7</sup> It is now felt that the risks of a patient developing a life-threatening reaction from NRL exposure appear to be lower than originally thought.<sup>8</sup> Furthermore, this risk may be reducing still as equipment manufacturers continue to phase out NRL from their product line. Most of the case reports of severe reactions due to undiagnosed NRL hypersensitivity appear to be in patients undergoing general anaesthetic procedures and most anaesthetists would prefer that high-risk patients be appropriately screened for true NRL allergy prior to general anaesthetic surgery.<sup>9,10</sup> Severe anaphylactic reactions have been described in patients undergoing procedures without general anaesthesia.<sup>11</sup> To our knowledge, there have yet to be any case reports of severe reactions in patients undergoing local anaesthetic cataract surgery.

We agree that current NRL hypersensitivity practice is probably based more on caution than evidence, and can sympathise with Mr Beare's opinion at what can be interpreted as being overcautious nonevidence-based practice. One can similarly understand why some trusts have adopted such a cautious approach to operating on NRL patients when the medical literature continues to report severe complications<sup>12-14</sup> and the emergence of litigation claims<sup>15</sup> resulting from NRL hypersensitivity. Ultimately, it is up to the individual eye unit to adopt a policy based on its own interpretation on the risks. It is likely that these policies will change as our understanding of NRL allergy increases.

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## Sir, Horner's syndrome as manifestation of Wegener's granulomatosis

Wegener's granulomatosis is a systemic inflammatory disease with a broad range of clinical manifestations. The complete form is characterized by necrotizing granulomatous inflammation of the upper and lower respiratory tract, glomerulonephritis, and systemic vasculitis. However, limited disease is not uncommon, and the presenting symptoms and signs may be highly variable.

Ocular disease is the presenting manifestation in 8-16% of patients, in which necrotizing sclerokeratitis and proptosis, caused by orbital inflammation, are most